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December 7, 2012

VIA ELECTRONIC FILING

Marlene H. Dortch, Secretary
Federal Communications Commission
445 12th Street, S.W., Room TW-B204
Washington, DC 20554

Re: Notice of *Ex Parte* in WC Docket No. 02-60

Madam Secretary:

In accordance with Section 1.1206 of the Commission's rules, 47 C.F.R. § 1.1206, we hereby provide you with notice of an *ex parte* presentation in connection with the above captioned proceeding. On December 5, 2012, the following individuals, accompanied by undersigned counsel, met with Angela Kronenberg, Legal Advisor to Commissioner Clyburn: Eric Brown, President and Chief Executive Officer of the California Telehealth Network ("CTN"), Brian Thibeau, President of the New England Telehealth Consortium ("NETC"), Kim Lamb, Executive Director of the Oregon Health Network ("OHN"), Kim Klupenger, Chief Operations Officer, OHN, and Hank Fanberg, System Director, Technology Advocacy at CHRISTUS Health, Executive Director of the Health Information Network of South Texas[1] ("HINSTX"), and Executive Director of the Texas Health Information Network Collaborative ("TxHINC"). The aforementioned were joined by David Muntz, Principal Deputy National Coordinator, ONC, and Jim Rogers, President, ProInfoNet. Mr. Muntz, Mr. Fanberg, and undersigned counsel attended in person, the others joined telephonically.

We discussed issues related to the Commission's long-awaited reforms to the RHC program with specific focus on why it is important that the Commission maintain a flat-rate discount that is as

[1] HINSTX is a Health Information Exchang e ("HIE") sponsored by the Office of the National Coordinator for Health Information Technology ("ONC"), U.S. Department of Health and Human Services ("HHS").

close as possible to the Pilot program's 85% discount level.[2] Meeting participants made the following points:

- **Reductions in the RHC discount below 85% will make it harder to form and maintain consortia of health care providers ("HCPs")**. We noted that Consortia have significant overhead costs funded by membership fees. We explained that the Bureau recognized that Pilot program benefits came principally from consortia – which drove increased competition and brought increased economies of scale to the procurement process. This increased competition not only reduced the cost and improved the quality and availability of broadband, but ensured program dollars were used more efficiently.

  We explained that reducing the discount will reduce consortium participation and could well negate some of these hard won benefits of the Pilot program. We explained that reduced consortium participation increases costs for remaining members and thus can create a cycle of increasing costs that further undermines incentives for participation.

- **The RHC program plays a critical role in meeting overall national health care reform goals.** We noted that all health care providers, but especially small and/or rural providers, are facing economic hardship while at the same time are being required by HHS rules to make substantial investments in technology. We explained that cutting back on the RHC discount could not come at a worse time and will make it harder, not easier for providers to meet already difficult federal policy objectives which rely on robust health information technology ("HealthIT").

  We also explained that health care providers are not deriving significant revenue from FCC subsidized broadband connections. We explained that most Rural Health Clinics and Critical Access Hospitals suffer chronically from low margins and many operate at a loss. We noted that to the extent broadband connections reduce the costs of care or otherwise avoid certain costs, such savings are not revenue.

- **The slow trajectory of RHC Pilot program demonstrates that the risk of hitting the $400 million RHC program cap will remain low for years to come.** We noted that the Pilot Program saw many projects either merge or drop out of the program and many of the remaining required several one-year extensions to ensure viability and/or successful completion. At a minimum, the Pilot program showed that even with an 85% subsidy, networks, particularly large consortia (such as represented by participants), were very difficult to establish and that the administrative overhead for such consortia remains substantial. We noted that administrative costs are a significant barrier to entry for new health care networks.

[2] *See Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket 02-60, Public Notice, DA 12-1166 (rel. Jul. 19, 2012) (*RHC PN*); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010).

In addition to the above, Mr. Brown discussed the challenges being faced in California by Rural Health Clinics and other rural providers. Mr. Brown noted that California state funding, which had been available to cover the Pilot Program match requirement, has been exhausted and that providers were preparing for the first time to pay the program match on their own (in addition to their CTN membership fees). Mr. Brown explained that many providers in California will be unable to bear a greater than doubling of the RHC program match requirement (from 15% to 35%).

Ms. Lamb discussed Oregon's statewide efforts to realize federal goals for health care reform, and highlighted the specific role of OHN in that effort. Mr. Lamb explained that broadband was a critical to achieving HHS' Triple Aim goals for health care. Ms. Lamb also noted that OHN serves as an important resource for health care providers adapting to the rapid changes in the industry and that OHN is often called on for expertise and assistance in adopting best practices that maximize the value of their broadband connections.

Mr. Thibeau explained that for NETC the Pilot program process took substantial time and effort and that the network procurement process alone took almost two years. NETC received its principle funding commitment letters over four years after its initial award and had only recently begun lighting sites on their network. Mr. Rogers, a consultant for NETC, explained that NETC had used the power of bulk purchasing to negotiate dramatic broadband discounts. Mr. Rogers explained that NETC had modeled total RHC program costs (assuming participation by 10,000 eligible HCPs) using the average prices and average bandwidths enjoyed by NETC members. This model – which assumed an 85% subsidy and the continued eligibility of non-rural HCPs – showed an annual demand for RHC funding well-below the existing RHC program cap.

Mr. Fanberg explained that FCC Pilot program's goals always anticipated close integration with national goals established by HHS and ONC. For example, Mr. Fanberg noted that Pilot program quarterly reporting continues to require regular reporting on how Pilot projects are furthering these goals.[3] Mr. Fanberg noted that broadband is frequently the forgotten piece of

[3] Items 11 and 12 of the Pilot Program quarterly reports indicate:

11. Provide detail on how the supported network has complied with HHS health IT initiatives:
    a. Explain how the supported network has used health IT systems and products that meet interoperability standards recognized by the HHS Secretary;
    b. Explain how the supported network has used health IT products certified by the Certification Commission for Healthcare Information Technology;
    c. Explain how the supported network has supported the Nationwide Health Information Network (NHIN) architecture by coordinating activities with organizations performing NHIN trial implementations;
    d. Explain how the supported network has used resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology;

the national HealthIT puzzle, but that broadband is nonetheless foundational to achieving federal HealthIT objectives. Mr. Fanberg also noted the challenges faced in forming consortia and the intensive administrative processes which made utilizing TxHINC's Pilot award take much longer than originally anticipated.

At the end of our meeting Mr. Muntz reiterated the value of telemedicine, particularly in rural communities. He noted that the benefits accrue first and foremost to patients, such as the rancher or farmer who does not need to leave the ranch or farm in order to receive treatment at a remote urban hospital. Mr. Muntz stressed the importance of broadband access to ONC's goals and expressed the desire to avoid a two-tiered system of quality for health care, between providers with affordable broadband and those without.

We thanked Ms. Kronenberg for her time and for Commissioner Clyburn's efforts on behalf of the Rural Health Care program. A copy of our presentation slides is enclosed. If you have any questions or require any additional information, please contact undersigned counsel directly.

Sincerely,

Jeffrey A. Mitchell
Counsel for
California Telehealth Network
New England Telehealth Consortium
Oregon Health Network
Texas Health Information Network
Collaborative

Enclosure

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e. Explain how the selected participant has educated themselves concerning the Pandemic and All Hazards Preparedness Act and coordinated with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and

f. Explain how the supported network has used resources available through HHS's Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) to facilitate interoperability with public health and emergency organizations.

12. Explain how the selected participants coordinated in the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (e.g., pandemics, bioterrorism). In such instances, where feasible, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

CALIFORNIA TELEHEALTH NETWORK

NETC

New England Telehealth Consortium

OREGON HEALTH NETWORK

Large Statewide Pilot Networks: *Broad-base of Experience with HCPs*

- ***California Telehealth Network***
  - 367 HCPs participating; 210 HCPs live on network
- ***New England Telehealth Consortium***
  - ME, NH, VT
  - 477 HCPs participating; 3 live on network, 8 per week going live starting next week (implementation FCLs issued May 2012)
- ***Oregon Health Network***
  - OR, WA, CA
  - 231 HCPs participating (208 live on network)

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Critical Issues

- **Doing More with Less: HCPs Challenged as Never Before**
  - *Effects of economic downturn*
  - *Demographics: aging populations; poverty; incidence of chronic illnesses; accident rates*
  - *Regulatory demands of health care reform*
  - *Restructuring of health care market: payment reform is coming!*

- **Health Care Reform Hinges on Technology**
  - *Federally Mandated Investments in Health IT*
    - *Displacing funds otherwise available for broadband*
  - *Pilot networks critical to rural HCPs' efforts to achieve meaningful use and exchange of EHRs and to participate in accountable care organizations (ACO's)*

- **Pilot Program Experience**:
  - *Inability to pay 15% match funding was most cited reason why HCPs declined to participate in Pilot Networks*
  - *Many RHCPP's depend upon annual network membership fees to cover admin costs; reducing discount percentage reduces revenue available to fund admin and reduces ROI for participating HCPs*
  - *Broadband connections not significantly improving bottom line*

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Rural HCPs: *Challenged as Never Before*

- **Lack of Financial Stability**

  "Many [Rural Health Clinics 'RHCs' in California] struggle with profitability and financial stability. More than half of RHCs (56%) did not make a profit in their last fiscal year, and 37% reported their current financial situation as being somewhat unstable or very unstable. Less than one-third of clinics reported that they were very financially stable."

  – Source: California HealthCare Foundation, 2012 Report, *California's Rural Health Clinics: Obstacles and Opportunities*

- **Uniquely Challenging Environment**
  – *Increasing poverty rates (Medicaid/Medi-Cal)*
  – *Increasing patient populations (incl. newly insured)*
  – *Decreasing reimbursements (esp. at state level); managed care*
  – *Declining number of health practitioners (avg. age over 60).*

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Impacts of Health Care Reform on HCPs

- *Health Broadband Subsidy Level Critical to Overall Federal Health Care Reform Effort*
  - Health IT upgrades stretching budgets to breaking point
    - Federal Health IT mandates
      - » HHS Triple-Aim: improve health of populations; improve patient experience & outcomes; decrease cost
      - » Meaningful Use & Exchange of Electronic Records
      - » Cost single most important factor in implementing EHRs and health IT/broadband-dependent new accountable care organization models
  - *RHC Pilot networks support HCPs in meeting meaningful use requirements*
  - *RHC Pilot networks are enabling federal efforts to reduce health care costs and increase access to care*

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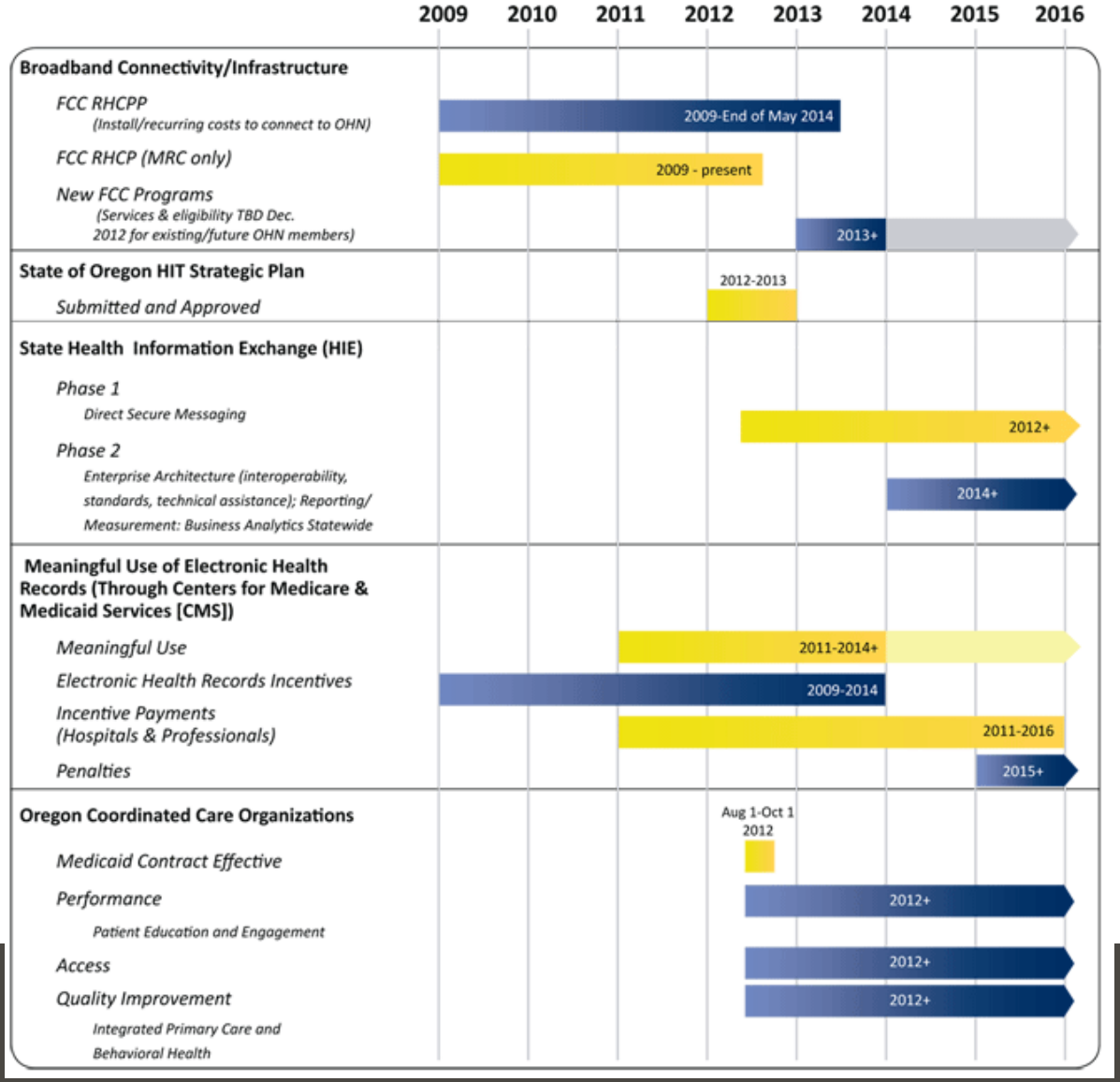
Oregon Health Reform Timeline



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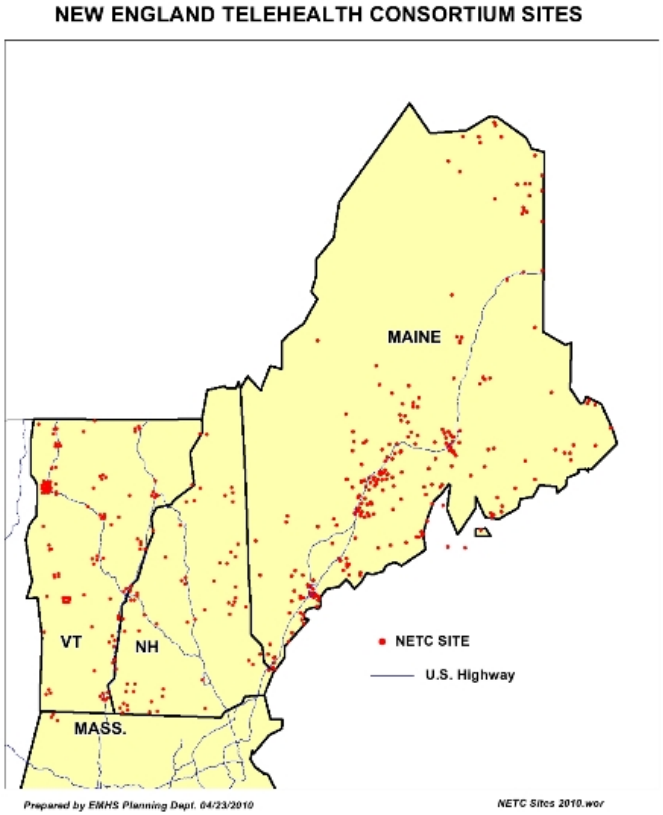
HCPs: *Challenged as Never Before*

- ***Consortia were key to realizing lower rates, higher bandwidth and better service quality in Pilot Program***
  - Estimated new program demand (based on NETC costs)
    - $8,000 average annual subsidy per HCP @85% over ten years (T1 thru 1 Gig) multiplied by 10,000 HCPs (total Rural Health Clinics and Hospitals nationwide) = $82 million annually
  - Consortia save program costs but are costly to establish and maintain
    - administrative costs are significant and typically collected through membership fees

- ***Lower discount level will mean fewer and smaller consortia***
  - Pilot Program 85% not enough for many HCPs
  - Cost single most frequently cited reason for non-participation

- ***NETC's experience***
  - Of original 477 HCPs, 112 dropped out with cost cited most often as the reason
  - Especially difficult when there are significant up-front costs (e.g., NRC's, pre-payments, or special construction).



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Concluding Observations

- ***Difficult times***
  - *Downturn plus unprecedented change means unprecedented challenges for HCPs, especially rural*
- ***Critical Role***
  - *Affordable broadband is a vital (foundational) part of the larger federal health reform effort*
- ***Never Easy***
  - *Even with 85% subsidy, virtually all Pilot networks struggled through start-up phases*

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Attendees

- Eric Brown, President and CEO, California Telehealth Network
- Kim Lamb, Executive Director, Oregon Health Network
- Kim Klupenger, Chief Operations Officer, Oregon Health Network
- Brian Thibeau, President, New England Telehealth Consortium
- Jim Rogers, President, ProInfoNet
- Hank Fanberg, Executive Director, Health Information Network of South Texas (also managing Texas Health Information Network Collaborative)

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